



The Children's Clinic, P.A.
264 Coatsland Drive • Jackson, TN 38301

Account Number: _____ Date: _____

Child's Name: _____ DOB _____ SSN _____ Sex M F

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Child's Name: _____ DOB _____ SSN _____ Sex M F

Child lives with Mother Father Both Grandparent Other _____

RESPONSIBLE PARTY DATA

Mother _____ DOB _____ SSN _____

Address _____ Phone _____ Cell _____

City _____ State _____ Zip _____

Employer _____ Phone _____

Father _____ DOB _____ SSN _____

Address _____ Phone _____ Cell _____

City _____ State _____ Zip _____

Employer _____ Phone _____

Emergency Contact (*Other than yourself*) _____ Phone _____

Address _____

City _____ State _____ Zip _____

I authorize any holder of medical or other information about my dependent to be released to the Department of Public Health or my insurance company in order to complete any claim or treatment that may be added.

Sign: _____ **Date:** _____

INSURANCE DATA

Primary

Secondary

Ins. Name _____

Ins. Name _____

Policy ID _____

Policy ID _____

Group _____

Group _____

Holder _____

Holder _____

I agree that the above insurance information I have given is correct. It is my responsibility to know what my insurance policy covers and if The Children's Clinic is in Network and/or I agree to pay any portion of the charges not covered by my insurance. If at anytime my insurance information changes, it is my responsibility to inform The Children's Clinic or it becomes my bill.

Sign: _____ **Date:** _____

In the event my account is placed with an outside agency for collection I agree to pay all collection cost, court, and attorney fees incurred to collect my account.

Sign: _____ **Date:** _____